THE HOSPITAL FOR
SICK CHILDREN

HEALTH RECORDS DEPARTMENT
555 University Avenue, Toronto, ON, M5G 1X8
Telephone: 416-813-7575; Fax: 416-813-5802

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorize ______________________________
(Name of facility releasing information)

to release to ______________________________
(Person/Facility to whom information is to be sent – Name, Full Address, Phone Number)

____

the following information: ______________________________
(Description of information to be released)

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from the record of ______________________________
(Patient's Name, Address, Phone Number)

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Date of Birth ______________ Medical Record Number ______________

Health Card Number ______________

The reason for this request is: ____Circle of Care ____ Lawyer ____ Insurance

Other ______________________________

****NOTE: In accordance with PHIPA (Personal Health Information Protection Act) authorization must be signed by the patient, and if incapable by the parent or substitute decision maker. A substitute decision-maker is a person authorized by PHIPA to consent on behalf of an individual, to disclose personal health information about the individual.**

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Signature of patient **(12 years and older)**

______________________________ ______________________________
Signature of parent/substitute decision maker Print name of parent/SDM and relationship

______________________________ ______________________________
Signature of witness Print name of witness

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Date and time

The Authorization for Disclosure of Personal Health Information is valid for 12 months. It can be withdrawn at any time by notification in writing to the Health Records Department.

Personal information contained on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act for the purpose of consenting to disclosure of personal health information. Questions about this collection can be directed to Debi Senger, Director Health Information and Registration Services, 416-813-7569.